

TUCSON POLICE DEPARTMENT

CRITICAL INCIDENT REVIEW BOARD

1361 NORTH FALCON RIDGE

APRIL 4, 2018



OFFICER INVOLVED SHOOTING

Table of Contents

Investigative Methodology	3
Incident Synopsis.....	3
Administrative Findings	4
Analysis	4-8
<i>Policies</i>	<i>4-5</i>
<i>Tactics and Decision Making.....</i>	<i>5-7</i>
<i>Supervision.....</i>	<i>7</i>
<i>Equipment.....</i>	<i>7</i>
<i>Use of Force.....</i>	<i>8</i>
<i>Training</i>	<i>8</i>
Recommendation and Learning Points	8-10

The following document is an analysis of an officer involved shooting that occurred at 1361 North Falcon Ridge on April 04, 2018. This incident meets the criteria to be classified as a sentinel event and analyzed for learning purposes by the department's Critical Incident Review Board (CIRB). This document provides an outline of the investigative methodology, findings of the administrative investigation, and a synopsis of the incident. There is an analysis of policies, tactics and decision-making, supervision, equipment, use of force, and training. The document concludes with the board's recommendations for changes and future learning opportunities.

Investigative Methodology

- Criminal Investigation
 - Investigative Services Bureau
- Administrative Investigation
 - Office of Professional Standards
 - Operations Division West Chain of Command Review
- Critical Incident Review Board
 - Pre-Board (October 30, 2018)
 - Board members were provided investigative files to review before the pre-board. They discussed the contents and determined the witnesses to be called and questions to ask.
 - Formal Board (December 13, 2018)
 - Witnesses and focus officers were interviewed.
 - Post Board (January 29, 2019)
 - Board members discussed the incident for conclusion and recommendations.

Incident Synopsis

The following is a synopsis of information obtained through the criminal and administrative investigations. The investigations included a review of written reports, body worn camera (BWC) footage, audio recordings, transcripts, interviews, and photographs.

On April 04, 2018, Officer Gustavo Castro and Officer Ashley Covarrubius responded to 1361 North Falcon Ridge in response to a report of a fight brewing. The initial 9-1-1 call reported four males arguing and pointing guns at each other outside of a residence. One of the involved subjects was in a wheelchair. The caller stated three of the involved males had left in a vehicle.

Officers Castro and Covarrubius parked their vehicles some distance away and approached the scene on foot. Eyan Gastelum, seated in a wheelchair, and his father, Carlos Gastelum, were on the sidewalk in front of the residence. As the officers approached the two men, Eyan yelled out something about "crossfire." Eyan and Carlos then began to struggle over a handgun in Eyan's hand. In the course of that struggle, Eyan stood up from the wheelchair and the handgun discharged into the air. Both subjects fell to the ground in the street. Eyan still had the gun in his hand. From his lying position in the street, Eyan pointed the gun at Officer Castro. In response, Officer Castro fired his duty weapon once, striking Eyan in the torso.

The officers broadcast over the radio they had been involved in a shooting. Officer Castro ran to his patrol vehicle to retrieve his individual first aid kit (IFAK) while Officer Covarrubius remained with Eyan and his family members. Officer Castro and Officer Covarrubius provided first aid to Eyan and directed the others present to stay back until additional police units and the Tucson Fire Department arrived on scene. Tucson Fire transported Eyan to Banner-University Medical Center for medical treatment.

Administrative Investigation Findings

Officer Castro's chain of command (COC) found his use of lethal force in firing one round at Eyan was justified and within department policy. The COC also found that that Officer Castro failed to activate his Body Worn Camera (BWC) when he arrived on scene, which violated General Orders 1330.2 and 3764. The sustained General Order violations were addressed in the form of restorative supervision (mentoring/counseling) and documented in a personal performance review.

Analysis

Department Policies

CIRB identified four areas of concern regarding policy:

- 1) Scene management and evidence collection;
- 2) Notification of letters of declination;
- 3) Activation of BWC; and
- 4) Use of protective gloves when rendering first aid.

1) Scene management and evidence collection

Officer Covarrubius and Officer Castro had a considerable amount of blood on their hands after rendering first aid to Eyan. Both officers recognized they should have put on protective gloves prior to rendering aid. The officers explained that the pace of the event and the significant nature of Eyan's wound simply caused them to forget to take precautions. Neither officer was permitted to wash their hands until they were photographed and processed by crime scene technicians hours after the shooting.

There was no evidentiary value to the blood on Officer Covarrubius. She was not involved in any type of physical altercation with Eyan prior to the shooting and her actions were captured by body worn camera. Other evidence sufficiently showed Officer Covarrubius physically present at the time of the shooting. Moreover, supervisors on scene could have captured the officer's appearance immediately after the shooting with their cellphone cameras and swabbed her for DNA. These actions would have allowed Officer Covarrubius to wash off the blood much earlier and potentially mitigate some of the stress she suffered. Allowing officers to clean blood off their hands when there is no evidentiary reason to preserve it can mitigate the impact of a traumatic event.

2) Notification of letters of declination

The Pima County Attorney's Office (PCAO) reviews all officer involved shootings to determine if the application of force was a violation of Arizona law. In this case, the PCAO determined there was insufficient evidence to prove Officer Castro committed an unjustified aggravated assault and declined to pursue any criminal charges.

Officer Castro learned that the PCAO declined to pursue criminal charges after he inquired about it through the Behavioral Sciences Unit. Detective Lockwood notified him via email that the Department had received the declination letter. Officer Castro stated he had not received a copy of the declination letter as of the time he was interviewed by CIRB. CIRB ensured Officer Castro was provided with a copy of the declination letter and recommends the department follow consistent standards to ensure focus officers are promptly notified about the status of any potential prosecution arising out of a critical incident.

3) Use of the body worn camera

Officer Castro violated policy by not activating his body worn camera when he arrived (General Order 3764). His actions were addressed by his chain of command.

4) Use of protective gloves when rendering first aid

Officer Castro and Officer Covarrubius both deviated from their training when they failed to don protective gloves prior to administering first aid. This is addressed in further detail in the analysis of training.

Tactics and Decision Making

A review of tactics used by Officer Covarrubius and Officer Castro is broken down into four categories:

- 1) Pre-arrival
- 2) Approach
- 3) Shooting
- 4) Post-shooting

1) Pre-arrival

Officer Covarrubius and Officer Castro recognized the potential danger associated with this type of call (fight or fight brewing). They had a third unit responding and they parked out of eyesight from the residence prior to going to the scene. Officer Covarrubius called the complainant and gathered real time information while they were responding. Officer Castro used his computer to search for previous police contacts at the location. The Air Support Unit responded to the area prior to the officers arriving on scene.

The Air Support Unit advised the responding officers there did not appear to be anyone fighting outside the residence. Officer Castro and Officer Covarrubius decided not to wait for the third unit based on the information provided by the Air Support Unit and the report

that several of the involved subjects were no longer on scene. Additionally, there were several other calls working in the division they felt would have benefitted more from the additional officer responding, therefore they canceled the third unit. Officer Castro told CIRB he was expecting to be able to take the report and go on to the next call.

2) Approach

The officers planned their approach in a manner so they would not drive in front of the house. They parked out of view and approached on foot. Officer Covarrubius did not use her flashlight while they were approaching so she would not give away her position.

Eyan could be heard yelling something about “crossfire” as the officers approached. Officer Castro recognized the reference to crossfire could indicate the presence of a weapon and began asking if anyone had a weapon. Eyan stood up from his wheelchair and began struggling with his dad over the gun. The gun discharged into the air. Eyan and his father both fell into the street.

Officer Castro dropped his flashlight and moved laterally while giving commands to “drop the gun.” Officer Covarrubius took a position of concealment behind a trashcan. Both officers responded appropriately to the gunshot by changing their physical location and drawing their weapons.

3) Shooting

Both officers responded appropriately when Eyan’s gun discharged while he was struggling with his father. Officer Castro drew his service weapon and moved to his left of where he was standing when the gun was discharged. Officer Covarrubius moved right and used a large plastic trash can as concealment. Both officers gave Eyan commands to drop the gun but he did not comply.

Officer Covarrubius was not able to see Eyan because his father fell on the ground between her and him. She made the appropriate decision not to fire her weapon without being able to adequately identify her target.

Officer Castro was in the street with nothing between him and Eyan. Eyan raised his gun in the direction of Officer Castro. Officer Castro discharged his weapon one time in response to what he identified as a lethal threat. The round struck Eyan and no further force was deployed.

Officer Castro exercised good decision-making and self-control in a high stress situation. He fired his weapon only as many times as necessary to adequately address the threat.

4) Post Shooting

Officer Castro approached Eyan immediately after confirming the lethal threat was neutralized. Officer Castro reported he heard Eyan drop the gun and saw that he was no longer holding it. Officer Castro attempted to kick the gun away from Eyan. He realized

that he kicked the gun in the direction of Eyan's family, so he kicked the gun a second time to get it further away.

Officer Castro began assessing Eyan to determine the appropriate level of aid to provide. Officer Covarrubius also approached Eyan and his family. Officer Covarrubius began speaking with Eyan's family who were argumentative and confrontational. In addition, the officers were facing an unknown threat in that they did not know who, if anyone, was still inside the residence.

Officer Castro and Officer Covarrubius did not secure Eyan in handcuffs or move him away from his hostile family members. They also did not secure Eyan's gun or place any of his family members in handcuffs. Any of these actions would have improved the security of the scene prior to rendering first aid. Officer Castro ran back to his patrol car to retrieve his IFAK; the officers lost visual contact with each other. Officer Castro and Officer Covarrubius both stated they recognize the potential danger of separating from each other, even for a brief period, while Officer Castro retrieved his IFAK. They both also acknowledged it would have been appropriate to take steps to make the scene more secure before rendering aid.

Supervision

Sergeant Robert Carpenter was monitoring the radio when Officers Castro and Covarrubius responded to this call. He heard the officers broadcast "shots fired" and responded to the scene.

Sergeant Carpenter assumed incident command and relieved Officer Castro and Officer Covarrubius from their duties. He asked them the appropriate supervisory questions including who had shot, which direction, and how many rounds. He also assigned them cover officers. Sergeant Carpenter made appropriate notifications, carried out necessary administrative duties, and worked to direct responding resources in an effort to secure the scene.

As additional resources, including command staff, began arriving at the scene an unsecured spent shell casing was observed on the sidewalk that had not been included in the scene perimeter. This raised concerns about perimeter security, overall scene integrity, and management. To complicate that concern, it was determined that a crime scene log and single point of access or egress to the inner perimeter had not been set up.

Overall, Sergeant Carpenter supervised this incident well. He stated that his firsthand experience with similar scenes was beneficial.

Equipment

There were no indications that availability of equipment was a problem. Officer Castro carries a patrol rifle but did not deploy it on this scene. His assessment of the situation resulting in his decision to leave his rifle in his vehicle on the approach was appropriate. The officers not donning protective gloves was not a result of the gloves being unavailable. Officer Castro not activating his camera was an error on his part and has been addressed by his chain of command.

Use of Force

The board concurs with the findings of the criminal and administrative investigations regarding the application of force.

Training

Officer Covarrubius and Officer Castro both said they were adequately trained to address this incident. Officer Castro specifically addressed the value of module training as it related to this incident. Officer Castro and Officer Covarrubius said they had received adequate training regarding donning protective gloves prior to rendering first aid and how to manage a scene immediately after using lethal force. Officer Castro stated he was taken by surprise when Eyan stood up from his wheelchair and thought training scenarios around this type of situation would be valuable in future trainings. Sergeant Carpenter also reported he felt adequately trained to manage this incident.

Recommendations and Learning Points

Policy

Supervisors should ensure they are familiar with training on how to manage officers who have suspect's blood on them after a lethal force encounter. Training to address this issue is available via Power DMS.

The board recommends establishing a policy to ensure members are provided a copy of the letter of declination in a timely manner.

ISB personnel are responsible for notifying members when the department receives these letters. It is recommended ISB consider using inter-office mail to notify focus member(s) and their chain of command. A copy of the letter should also be sent to the member via email.

Violent Crime Commander Lieutenant John Carlson informed CIRB that he is in the process of proactively taking steps to address this issue. His identified solution was similar to the aforementioned suggestions.

The board recommends supervisors be familiar with body worn camera policies and ensure their officers are complying.

This incident involved a violation of policy regarding the use of a body worn camera. A policy is in place requiring supervisors to audit body worn camera use to ensure there are no patterns of noncompliance. Failing to activate a body worn camera has been added to the discipline thermometer to ensure consistency in addressing violations.

The board recommends revisiting policies regarding how witness officers are treated after an incident of this nature.

Incidents of this nature can have a significant impact on all members who were directly involved, not just those who applied force. There are several steps in place to ensure the needs of the focus officers are met. The same level of responsiveness should be available to witness officers when appropriate. Witness officers may experience similar reactions to high stress situations as some focus officers. This can include auditory exclusion, tunnel vision, memory loss, and other changes associated with traumatic stress. Services such as reintegration training prior to returning to work could be beneficial for witness officers.

Tactics and Decision Making

The board strongly recommends officers stay diligent and avoid complacency in handling calls for service or other matters that may become routine based on their frequency. This should be a frequent topic of conversation between supervisors and their subordinates as well as among peer groups.

The officers' actions prior to the shooting should be commended. The steps they took prior to making contact show they were thoughtful and very aware of the potential danger. However, this incident also highlights the potential danger of being overly reliant on information obtained prior to going on scene and assumptions that can be made about individuals we contact.

The board recommends the department promote officer self-discipline and round accountability when utilizing deadly force. Outstanding self-discipline in the use of deadly force and round accountability should be recognized and acknowledged.

Officer Castro exhibited good decision-making and self-control in a stressful situation. He fired his weapon only one time and his shot was accurate. Round accountability is becoming a focus of conversation in the law enforcement profession. This incident highlighted appropriate decision-making and accountability by the involved officers.

The department implemented training with the impact of stress on field performance. The board recommends this continue to be a topic that is addressed through training.

There are some areas of concern regarding decision-making immediately following the shooting. The officers separated from each other and did not appropriately secure and control the scene prior to rendering first aid. Both officers reported they have been trained on how to address this type of situation. The board believes the stress and intensity of the situation impacted the officers' decision-making process. The board further recognizes that stress impacts decision-making and is not critical of the officers for being susceptible to this. Continued training around stress-management associated with critical incidents for all officers will be valuable and potentially lifesaving.

Supervision

The board recommends supervisors continue to receive training on how to manage complex scenes of this nature. The training should include opportunities for supervisors to respond to certain critical incidents, even if they won't be directly responsible for scene management, in an effort to increase their first-hand exposure and experience.

Sergeant Carpenter reported his first-hand experience at various prior scenes in conjunction with the formal training he had been given helped him be prepared to supervise this incident.

The board recommends incident commanders ensure the inner perimeter at this type of scene is secure. A crime scene log should be established and a single point of access and egress should be identified.

The board recommends the command post be established outside of the inner perimeter.

The board reminds all members to respect the crime scene and not enter the inner perimeter unless necessary and authorized as part of the investigative team.

Training

All members reported the training they have received has been adequate to help them respond to this incident.

The board reminds all members it is everyone's responsibility to adhere to training as it relates to personal safety. This includes being mindful of small details such as donning personal protective equipment prior to rendering first aid.

Training regarding the donning of protective equipment has been provided in multiple formats to include basic first aid, IFAK training, and annual OSHA updates.

Supervisors are encouraged to address issues of this type with their subordinates regularly.

The Critical Incident Review Board was comprised of the following members:

- Deputy Chief Chad Kasmar
- Captain Joe Puglia
- Lieutenant Colin King
- Lieutenant Alisa Cunningham
- Lieutenant Jennifer Pegnato
- Lieutenant Brian Parker (retired)
- Lieutenant Dave Leotaud
- Lieutenant James Brady
- Lieutenant Troy Perrin
- Sergeant Steve Simmers
- Officer Brandon Echols
- City Attorney Julianne Hughes
- City Attorney Rebecca Cassen
- Independent Police Auditor Liana Perez
- Independent Police Auditor Mitch Kagan
- Community Member Anita Kellman
- Community Police Review Board Member Glen Perin
- Public Safety Communications Supervisor Ana Corcoran